GENERAL ETHICS

A NICE fallacy

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A response is given to the claim by Claxton and Culyer, who stated that the policies of the National Institute for Health and Clinical Excellence (NICE) do not evaluate patients rather than treatments. The argument is made that the use of values such as quality of life and life-years is ethically dubious when used to choose which patients ought to receive treatments in the National Health Service (NHS).

Recent articles by Rawlins and Dillon[1] and Claxton and Culyer[2] have left me some what disturbed by what seems to be the received wisdom at the National Institute for Health and Clinical Excellence (NICE) regarding healthcare in general and quality-adjusted life years (QALYs) in particular. I wish to respond to a specific claim that grabbed my attention in the article by Claxton and Culyer. The assertion they make is that the policy that NICE adopts evaluates the worth of treatments and not of patients.

Claxton and Culyer's article is a response to a previous editorial by Harris,[3] in which he maintains that ''NICE should not be in the business of evaluating patients rather than treatments''. The authors object to this assessment particularly because Harris[3] condemns this type of evaluation as ''contrary to basic morality and contrary to human rights''. They concede that there is indeed a difference between evaluating treatments or procedures and evaluating patients, but deny that NICE's policies amount to doing the latter. They allege that the kind of cost-effectiveness appraisals that take place ''compare(s) the worth of alternative procedures, but this is not the same as evaluating the *worth* of patients'' [my emphasis].[2] Indeed, they agree with Harris that to do so would be morally wrong. Why is it then that they cannot see that this is exactly what is happening?

At the risk of simply reiterating points that have already been made, I must turn to NICE's endorsement of the QALY to explain why I think that they are indeed ''in the business of evaluating patients rather than treatments''.[3] In the series of articles and editorials that have been published on the subject, all parties seem to concur that there are two applications of the QALY. The first of these is to decide between two alternative treatments for the same person. Here there is no dispute that we are truly evaluating treatments. We are simply trying to select the best possible treatment for the individual patient. The second application, however, is the one causing the current discord among the authors. Here the QALY is used, not to choose the best treatment for a particular patient, but to either choose between the *same* treatments for *different* patients or between *different* treatments for *different* patients. This is contentious because one camp alleges that applying the QALY in this manner is to make value judgements about people's lives, while those at NICE maintain that no value judgements are made. Unfortunately, values are the basis of the QALY. This is because the standards it uses measure the worthiness of patients for treatment in respect of qualities that they possess: *quality of life* and *life-years*. For that reason, any health instrument which uses these values in decisions about resource allocation is making the type of value judgements that we would normally wish to avoid. If I need to decide whether to give a treatment to either patient A or patient B and I utilise the QALY, then I am effectively balancing the improvement (or deterioration) in the quality of A's life multiplied by the number of life-years he gains (or loses) against the same calculation for B. The best score will determine which person will be the most cost effective to treat from my limited resources. Unfortunately, what we are doing when we engage in this type of calculation, in particular, is making value judgements about the lives of those two patients (identifiable or not), because the result is that their lives and health are given lower priority. More generally, we are making value judgements about the kind of people who have worthwhile lives or, indeed, about which types of lives the NHS should attempt to save or ameliorate. Now, it may be that the people at NICE think that this is morally acceptable since the authors clearly state that ''NICE's use of QALYs embodies representative value judgements of the UK population'',[2] but the complicity of the masses does not necessarily make it so. It is in fact far from clear that NICE has even achieved such complicity. Research conducted by Erik Nord[4] in Norway suggests that the public views patients as individually valuable and equally entitled to treatment regardless of the health outcome (p 41).

In a healthcare system that purports to evaluate and treat each patient in a fair and equal manner, it is not acceptable that you, I, NICE or anybody else for that matter, make policy-affecting value judgements about the lives of other people because when it comes to determining the value of people's lives our opinions simply do not matter. This may be construed, as were Harris' comments, as ''a denial of the allocation problem in healthcare'' (p 373),[2] but that is not my purpose. If we are to say that life is valuable (and on this I think we can all agree), then we need to ask why a person's life is

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Abbreviations: NHS, National Institute for Health and Clinical Excellence; QALY, quality-adjusted life year

valuable. The answer, which has been restated many times by Harris himself, is not that you, I, NICE or anybody else values that person's life, but that that person values his or her own life.[5] People and patients do not have to justify the value that they place on their own lives, it is simply enough that they do value them and wish to go on living. Consequently, they should not have to justify their need for medical treatment in terms of expected improvement in the quality of their lives or an increase in their life-years. Where people value their lives they ought to be treated with equal ''concern and respect''[6] regarding this. Consequently, they have the ''right to equal concern and respect in the political decision about how these goods and opportunities are to be distributed''.[6] When we use QALYs to choose between people, we take away the patients' rights to make value judgements about their lives for themselves.

While Claxton and Culyer maintain that the use of this method of resource allocation is not evaluating the worth of patients, it seems patently obvious to me that it does. When we engage in the sort of evaluations inherent in QALYs, we make value judgements about the kind of people that we think are worth the expenditure of public resources. Specifically, we are saying that we think those people who belong to a particular category have more worthwhile lives. By using the QALY we are implicitly (or perhaps explicitly) accepting that those patients with a better quality of life and who live longer have more worthwhile lives. Although it may be acceptable to hold a private opinion regarding this, we ought not permit these personal conclusions to creep into public policy.

In a world where there are limited resources and competing healthcare interests many have argued that there is no alternative to the QALY, but, of course, there are alternatives albeit unpopular ones. The two that spring easily to mind would be either a first-come first-served or a random lottery system where all citizens would have equal opportunity of access to the system. Both these types of approaches to healthcare could be seen to fulfil the important criteria of justice and fairness where we do not want our conception of justice to involve selection criteria that embody value judgements about people. Nord's[4] study, mentioned above, also suggests that people might prefer a first-come, first-served system to a QALY-based one (p 38). However, those who believe that resources should be allocated on the basis of priority, need or one's just desert would not sign up such schemes. In addition, one might argue that these kinds of systems do not value all lives equally by virtue of the fact that some would be treated and others would not. Therefore, a better option might be to redirect all healthcare moneys into public health and preventive medicine. This would ensure an equality of opportunity regarding healthcare for all people, thus valuing all lives equally, while still respecting the need for justice and fairness. Focusing on public health and prevention may eventually improve the general level of health in the population, and prevent a significant amount of illness. If this is true, then increasing the level of health at a population level would have the effect of decreasing national expenditure on healthcare services, giving us the scope for the wider use of our limited resources. Specific examples of the successful implementation of public health measures that have had the above effects are our national immunisation programmes. In particular, the one against *Haemophilus influenza B* in children has almost eliminated the deaths and the comorbidities from the associated meningitis.[7] This reduces immediate healthcare costs associated with treating the illness, and also ensures that a significant number of children, who might not otherwise have done so, grow up to contribute to the society and the economy.

CONCLUSION

As we have seen, the QALY can be, and in fact is, used to choose between patients and it is the continuing use and endorsement of this particular aspect of the QALY which means that not only is the QALY morally contentious but so is any wider policy into which it is incorporated. The QALY by its very nature incorporates certain values (quality of life and life-years), and when these values are the basis of choosing between patients competing for healthcare resources then it can be said to make implicit value judgements on the lives of these patients. Therefore, it is simply a fiction to say that the QALYs do not evaluate the worth of patients because this is exactly what it does and by adopting them as the standard this is also what NICE is doing. We cannot deny the resource allocation problem in healthcare but we also cannot deny the ethical problems inherent in resource allocation. Only an acceptance of these difficulties by all parties will lead us to a more ethical and equitable solution than the one currently in operation.

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